PRINTED: 05/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	DGE	·	505	ET ADDRESS, CITY, STATE, ZIP CODE 5 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN ( PREFIX (EACH CORRECTIVE A: TAG CROSS-REFERENCED TO DEFICIE		LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F	000			
		ns represent the findings of a nvestigation of complaint #					
	A revised copy of the facility on 5/4/12.	deficiencies was sent to the					
F 205 SS=D	483.12(b)(1)&(2) NOT POLICY BEFORE/UF		F	205			
	hospital or allows a releave, the nursing facinformation to the resor legal representative of the bed-hold policy during which the residence the nursing facility's periods, which must be (b)(3) of this section, return.						
	facility must provide t member or legal repr which specifies the di	rapeutic leave, a nursing of the resident and a family esentative written notice uration of the bed-hold policy oh (b)(1) of this section.					
	by: The facility had a cersample included 15 record review and interprovide a bed hold po	ris not met as evidenced risus of 59 residents. The esidents. Based upon erviews the facility failed to blicy to 1 (#32) of 1 sampled tember after the resident					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		175455	B. WIN	B. WING		05/0	2/2012
	ROVIDER OR SUPPLIER	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 5 N. MAIN ST. SKRIDGE, KS 66423		2/2012
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F 205	was admitted to the h Findings included:  Review of resident Order Sheet identified that included: disorgate bacterial pneumonia, abcess of the upper a rash, disturbance of sesophageal reflux, irring hemorrhage of the regastroduodenitis with extrapyramidal and a disorder, allergic rhin hypercholesterolemia.  A nurse's noted dated documented the resident he nursing station, so falling straight backwaprevent the fall, and so left leg was rotated on his/her right leg. The voiced pain during rateg and voiced pain to head, the resident had the facility received a transport the resident emergency room for one of the control of the resident emergency room for the resident emergency room for the resident emergency room for the residence the facility period of the residence the facility	#32's April 2012 Physician de the resident had diagnoses anized schizophrenia, dyspepsia, cellulitis and and forearm, constipation, salivary secretion, itable bowel syndrome, ctum and anus, gastritis and hemorrhage, bnormal movement itis, and designed and the staff observed the resident ards with not enough time to staff observed the resident and some the staff of the right side of his/her definition, and physician's order to	F	205			

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F 205	the resident and/or a resident was admitted. Review of the resider entry record with an a of 3/1/12 recorded the facility on 3/1/12.  During interview with 5/1/12 at 5:15 P.M. th not provide a copy of at the time of the tran not aware the hospita resident. Administrat did not provide a bed and/or a family memiadmitted to the hospit. The facility's transfer, leave, room change a	rovided a bed hold notice to family member after the d to the hospital.  It's Minimum Data Set 3.0 assessment reference date e resident returned to the example of the desire that the bed hold to the resident sfer because the facility was all was going to admit the five Staff A stated the facility hold notice to the resident over after the resident was	F	205			
F 279 SS=D	legal guardian within included the transfer.  The facility failed to p family member a copy the resident was adm 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE DIA COMPREHENSIVE Plan COMPREHENSIVE Plan COMPREHENSIVE DIA COMPREHENSIVE DIA COMPREHENSIVE PLAN COMPREH	rovide this resident and y of the bedhold policy after itted to the hospital.  1) DEVELOP CARE PLANS  e results of the assessment d revise the resident's	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	medical, nursing, and needs that are identifical assessment.  The care plan must do to be furnished to attain highest practicable prospectors of the facility had a ceres ample included 15 record observation, rethe facility failed to decare that identified the (#4) of 1 residents ideal services.  Findings included:  Review of residents ideal services.	bles to meet a resident's mental and psychosocial ed in the comprehensive  escribe the services that are also or maintain the resident's anysical, mental, and any as required under vices that would otherwise 33.25 but are not provided exercise of rights under eright to refuse treatment  is not met as evidenced  assus of 59 residents. The esidents. Based upon ecord review, and interviews evelop a coordinated plan of exercise for 1 entified for Hospice  #4's Physician Order Sheet ed the resident had ed: psychosis, history of generalized pain, topenia, anxiety, er, dementia with lewy effux, malignant neoplasm of directum, epilepsy, peripheral vascular disease,	F	279			

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F 279	coordination, edema, personality disorder, I intestinal malabsoprti.  The resident's signific Set (MDS) 3.0 with an date (ARD) of 3/29/12 short and long term in behaviors, did not wa required extensive stativities of daily living did not have a conditi might result in a life emonths.  The resident's Cognit Area Assessment (CA documented the resident received end of life care, the facthange in the resident changes, and coordin plan with Hospice. The tinclude the frequency provided nor did it incompliated to a diagnosis of expectancy of less the	nutritional deficiency, hypothyroidism, and on.  ant change Minimum Data in assessment reference identified the resident had be mory problems, displayed lik in the room or corridor, aff assistance with all other ig, utilized a wheelchair, and on or chronic disease that expectancy of less than 6  and atted 4/12/12 lent currently received  and atted 4/19/12 included Hospice Services related to incility notified Hospice of any it's condition or medication atted the resident's care the resident's care plan didency or services Hospice lude what medications, redical equipment Hospice ent.  13/28/12 (time unknown) or receive Hospice Services dementia with a life an 6 months.  M. the resident sat in a	F	279			

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F 279	Observation at that tir utilized a low air loss mattress in place.  During interview with 4/30/12 at 4:37 P.M. received Hospice sent the services, equipme provided for the reside.  During interview with approximately 2:00 P resident received Hos residents MDS with a include the resident hithan 6 months. The siphysician's order was confirmed the resident the care and services.  During interview with 5/1/12 at approximate confirmed the resident the care and services.  The facility's Delivery Death, and Dying Pol October 2009 include would be documented section of the medical would be coordinated.	M. the resident was in bed. me revealed the resident bed, and had a scoop type  direct care staff J on the staff stated the resident vices but did not know what ent, or supplies Hospice ent.  dicensed nurse I on 5/1/12 at .M. the staff confirmed the spice Services and the n ARD of 3/29/12 did not ad a life expectancy of less taff confirmed the dated 3/28/12. The staff tt's care plan did not identify the hospice provided.  Administrative Staff A on ely 2:30 P.M. the staff tt's care plan did not identify the hospice provided.  of Service Terminal Illness, icy and Procedure revised d all services provided d in the social service I record, and the care plan	F	279	,		
F 309		ng facility would provide.	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309 SS=D	provide the necessary or maintain the higher mental, and psychosome	NG eceive and the facility must y care and services to attain st practicable physical,	F	309			
	by: The facility had a cer sample included 15 re observation, record re	is not met as evidenced usus of 59 residents. The esidents. Based upon eview and interview the e that 1 (#10) of 1 residents and during meals.					
	- Review of resident dated 4/11/12 identific diagnoses that includ disorder, cataract, hy rash, edema, insomn bodies, esophagus di bipolar type I, anxiety hemiplegia affecting of borderline personality disorder, infantile cere lymph nodes, and cere (CVA).	ed: Schizoaffective pertension, constipation, ia, dementia with lewy sorder, neurogenic bladder, , hypopotassemia, flaccid dominant side, psychosis, o disorder, depressive ebral palsy, abdominal rebral vascular accident					
	an assessment reference 10/31/12 identified the	Minimum Data Set 3.0 with ence date (ARD) of e resident scored a 14 ne Brief Interview for Mental					

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F 309	bed mobility, transfers the unit, dressing, toil in the room or corrido assistance with eating did not have swallowi. The resident Activities area assessment date resident had a long te impairment related to required extensive starequired staff assistant the bed and chair, stato propel the wheelch promote independent swallowing difficulties. The resident's quarter 4/2/12 identified the re (moderately impaired not exhibit any behav assistance with eating staff assistance with a The resident's care plincluded the staff set provided proper positientry dated 4/18/12 dreceived a referral for speech therapy for eveating, swallowing, sechoking. The care pla 12/30/11) the residen in the wheelchair inclutilted in space at the roptimize his/her positi	nsive staff assistance with s, locomotion on and off of et use, hygiene, did not walk r, required limited staff g, utilized a wheelchair, and ng difficulties.  Is of Daily Living (ADLs) care ed 11/14/12 documented the erm history of physical a CVA, and cerebral palsy, aff assistance with ADL's, noce with positioning while in eff encouraged the resident air by himself/herself to be, and did not have the end of the esident scored a 11 cognition) on the BIMS, did iors, required limited staff g, and required extensive	F	309			

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F 309	mobility.  A physician's order of included for physical therapy, and speech evaluation and treat resident's positioning swallowing.  A nurse's noted 4/18 documented the resident, the resident, the resposition, and staff recoughing episodes of the coughing episodes of the	dated 4/18/12 (time unknown) I therapy, occupational In therapy to conduct an as indicated relating to the g in the wheelchair and  8/12 timed 12:42 P.M. ident sat in the Broda chair left side, staff repositioned ident returned to the slumped eported the resident had while eating meals.  8/4/20/12 timed 1:43 P.M. ident continued to use the tilt position to optimize his/her  PT) plan of care dated the resident was referred to eficits due to congenital ight spastic hemiplegia, had itioned in a Broda peddler, the the resident had positioning the month which had resulted in lso had some swallowing e cannot maintain an upright	FS	809				

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F 309	plan of care included difficulties caused by resident's eating habiduring meals which paspiration.  On 4/30/12 at 7:50 A Broda chair at the dirposition. At this time breakfast meal which and a bowl of cold ce (after the resident wa care staff J placed the position and the resident was care staff J placed the position and the resident was in the back of the read "Please recline At 8:03 A.M. the resident was tarted to cough.  On 5/1/12 at 7:50 A.M. Broda chair at the dirbreakfast meal, and the position. At that time hard for him/her to recare staff J at that time was not in the upright staff J placed the charesident then stated (chair in the upright position). The proposition of the food, smiled and on 5/1/12 at 12:18 P dining room table in the resident stated he in the chair. At that time	the resident had swallowing cerebral palsy, the ts and poor positioning laced the resident at risk for the staff delivered the resident's consisted of eggs, muffin, real cereal. At 8:02 A.M. seating the meal) direct earned chair in the upright lent did not slump as much. The resident's Broda chair that the when I am not dining. The dent ate his/her meal and the resident stated it was the ach his/her food. Direct the stated the Broda chair the the stated the Broda chair the ach his/her food. Direct the stated the Broda chair the stated the Broda chair. The after the staff placed the stated thank you.  M. the resident sat at the the Broda chair. At that time the Broda chair at the the Broda chair. At that time the Broda chair at the the Broda chair. At that time the Broda chair at the the Broda chair at the the Broda chair. At that time the Broda chair at the the Broda chair at the the Broda chair at the the Broda chair. At that time the Broda chair at the the Broda cha	F	309			

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F 309	resident stated it was  During interview with 9:40 A.M. the resident was uncomfortable downwas to promote with piscale downwas to promote proper for the resident at the highest position downwas to promote proper for the resident at the highest position when the resident at the highest position when the resident at the higher manner that the higher m	the resident on 4/30/12 at t stated his/her positioning uring meals, and that he/she gher during meals. The t times he/she had coughing s.  nursing administrative 0/12 at 3:19 P.M. the staff concerns about the nd swallowing difficulties and should be a reclining position when the staff stated the Broda a reclining position when the remaining meals.  therapy consultant M on the consultant stated the aring he in the highest upright ident ate his/her meals.  licensed nurse G on 5/1/12 stated the Broda chair the highest upright ident ate his/her meals.  Licensed staff stated the aring the position when the leals. Licensed staff stated the leals aring the leads of the policy ded the purpose of the policy	F	309			

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F 309 F 329 SS=E	positioned in the Broo	aff assistance with and at risk for aspiration was la chair appropriately. IMEN IS FREE FROM		309 329			
	unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate moi indications for its use.	· •					
	resident, the facility method have not used an given these drugs unla therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention.	ensive assessment of a nust ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and ns, unless clinically effort to discontinue these					
	by: The facility identified The sample included observation, record re	is not met as evidenced a census of 59 residents. 15 residents. Based on eview and staff interview, the by and monitor targeted					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 329	of the ten residents in medications (#31, #4) Findings included:  - Resident #19 had paranoid schizophre and recurrent seizur tremor, anxiety disorbodies, nutritional dedisturbance, depressed disturbance of skin separkinson's, bipolar behavioral disturbance sophagus, peripheranemia, obsessive of mellitus type I, and of Physician's Order SI The POS also included Lunesta 1 milligram Cymbalta 60 mg., and 0.25 mg., an anti-psyanti-psychotic, and hanti-anxiety.  The quarterly Minimum an Assessment Referecorded a Brief Interecorded a Brief Interecorded a Brief Interecorded and the anti-anxiety, anti-psymedications.  The Care Area Asset 12/14/11 for psychologoumented he/shemental illness with the second of the sec	diagnosis that included nia, plantar wart, epilepsy es, constipation, essential der, dementia with Lewy eficiency, insomnia, sleep sive disorder, hypothyroidism, sensation, secondary disorder, dementia with ce, gastroparesis, Barrett's ral angiopathy, cardiomegaly, compulsive disorder, diabetes estaract as listed on the April neet (POS) dated 4/11/12. Ided the following medications: (mg.), a sedative/hypnotic, n anti-depressant, Risperdal cychotic, Geodon 60 mg., an and compute the control of the	F	329			

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with no new recom Advanced Register noted he/she was redose reduction.  The care plan date 3/20/12 recorded a cognitive or behavior psychotropic medical listed nursing staff noted any decrease nursing staff reported changes in sleeping nursing staff reported paily Living (ADL) of the pharmacist reverse a monthly basis, and sugar candy for dry.  The Behavior Month listed the following anxiety, continuous hallucinations/paral and refusing care. The medications: Lunes 60 mg., Risperdal (Klonopin 0.5 mg. The medications were resident consumed table, stood up from the floor, then ambulant interview on 5/1 nursing staff F indical control in the floor, then ambulant interview on 5/1 nursing staff F indical control in the floor, then ambulant interview on 5/1 nursing staff F indical control in the floor, then ambulant interview on 5/1 nursing staff F indical control in the floor in the floor, then ambulant interview on 5/1 nursing staff F indical control in the floor in the	n review on a monthly basis mendations noted. The red Nurse Practitioner (ARNP) not a current candidate for d 12/29/11 and last reviewed potential for drug related oral impairment due to reation usage. The interventions monitored fluid intake and red intake to the charge nurse, red behavioral changes or g pattern to the charge nurse, red changes in Activities of function to the charge nurse, riewed medication regimen on and he/she was offered hard or mouth.	F	329			

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F 329	provide information of behaviors related to conserve of the facility Behavior Managemer 2011, recorded "prior antipsychotic medical obtained to include the behaviors that warrant."  The facility failed to include the facility failed the facility failed the facility failed the fa	orresponded to the s.  2 at 1:15 P.M. with g staff C was unable to n residents' targeted diagnosis and medications.  policy/procedure for nt Guideline revised January	F 32	29			
	paranoid schizophren due to mental disorder depressive disorder, amputation of arm an elbow, anxiety, constitueyes, and agoraphob listed on the April 201 (POS). The POS inclumedications: Trazodo anti-depressant, Clozanti-psychotic, Celexanti-depressant, and anti-anxiety.  The quarterly Minimu an Assessment Reference.	esophageal reflux, traumatic d hand unilateral below ipation, blindness of both ia with panic disorder as 12 Physician's Order Sheet uded the following one 250 milligrams (mg.), an aril 250 mg., an a 20 mg., an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. B			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G	<del></del>	05/02	2/2012
	OVIDER OR SUPPLIER	OGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	medications.  The Care Area Assest triggered for psychotr.  The care plan dated \$2/16/12 listed psychotr for side effects and tate Trazadone, Clozaril, \$6.  The Behavior Monthly listed the following beyelling, and hyperven following medications Clozaril 250 mg., Celemg. This sheet did nowere related to which.  An observation on 4/3 resident was observe entering from the smotholding cane and requinim/her to room, staff his/her room, resident during ambulation.  An interview on 5/1/12 nursing staff F indicat listed beside the prestargeted behaviors coappropriate diagnoses.  An interview on 5/1/12 administrative nursing provide information of	resident received nxiety, and anti-depressant sment (CAA) dated 8/25/11 opic drug use.  9/30/11 and last reviewed tropic medication monitoring regted behaviors included: Celexa, and Klonopin.  Flow Sheet for April 2012 haviors: anxiety, continuous tilating. The sheet listed the : Trazadone 250 mg., exa 20 mg., and Klonopin 1 t specify which medications behaviors.  80/12 at 10:20 A.M. the d near the entrance door oking area, resident was uested staff to assist escorted the resident to the did not use walking cane  2 at 11:45 A.M. licensed ed that the diagnoses were cribed medications and the wresponded to the staff C was unable to	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G	·	05/02	2/2012
	OVIDER OR SUPPLIER	OGE	·	5	REET ADDRESS, CITY, STATE, ZIP CODE 605 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		LD BE	(X5) COMPLETION DATE	
F 329	Continued From page	: 16	F	329			
	2011, recorded "prior antipsychotic medicat obtained to include the behaviors that warrant. The facility failed to idefficacy and side effect medications.  - Resident #43 had dischizoaffective disord tissue infections, aller post-traumatic stress personality disorder, emellitus type II, urinar varicose veins of lowe ovaries, obesity, hirsu atherosclerosis, tobac myalgia and myositis, fibroadenosis of breast loss, lumbago, extern symptomatic menopa states, psychosis, real joints of pelvic region osteoporosis, constipamigraine, extrapyrami hypertension, and ins Physician's Order She The POS included the Zyprexa 10 milligrams	agnosis that included er, skin and subcutaneous gic rhinitis, hypertension, disorder, borderline esophageal reflux, diabetes y incontinence, rosacea, er extremities, polycystic atism, coronary coo use, hyperlipididemia, osteoartherosis, anemia, st, sensoneural hearing al thrombosed hemorrhoids, usal/female climacteric citive confusion order is entitation of the provision of the psychotropic entities and subcutaneous gic rhinitis, hypertension, disorder, borderline esophageal reflux, diabetes y incontinence, rosacea, er extremities, polycystic entitism, coronary coo use, hyperlipididemia, osteoartherosis, anemia, st, sensoneural hearing al thrombosed hemorrhoids, usal/female climacteric citive confusion, pain in					
	The quarterly Minimul	m Data Assessment (MDS)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WING	3		05/0	2/2012
	OVIDER OR SUPPLIER	DGE		505	ET ADDRESS, CITY, STATE, ZIP CODE  N. MAIN ST.  KRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	2/17/12 recorded a B Status (BIMS) of 15 a anti-psychotic and an The Care Area Assestriggered for psychotron The care plan dated 9 2/16/12 listed psychofor side effects and ta Ativan, Paxil and Zyp The Behavior Monthly listed the following be screaming/yelling, hallucinations/parano hoarding, damaging pitems and then accus sheet listed the following., Ativan 1 mg., an An observation on 4/3 the resident sat at the straight back chair.  An interview on 5/1/1 nursing staff F indicat listed beside the prestargeted behaviors coappropriate diagnose.  An interview on 5/1/1	ent Reference Date (ARD) of rief Interview of Mental and the resident received ti-depressant medications.  Sesment (CAA) dated 12/6/11 ropic medication usage.  2/30/11 and last reviewed tropic medication monitoring argeted behaviors included: rexa.  2/ Flow Sheet for April 2012 rehaviors: anxiety, continuous ria/delusions, isolation, property, and giving away ring others of stealing. This ring medications: Zyprexa 10 d Paxil 10 mg.  30/12 at 12:30 P.M. revealed redining room table in a responded to the second medications and the presponded to the second medication of the second medication	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG		05/0	2/2012
	OVIDER OR SUPPLIER	DGE	1	5	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PL PREFIX (EACH CORRECTIV TAG CROSS-REFERENCE DEF		JLD BE	(X5) COMPLETION DATE
F 329	2011, recorded "prior antipsychotic medica obtained to include the behaviors that warrar.  The facility failed to idefficacy and side effermedications.  - Resident #46 had deschizophrenia, edemoder edepressive disorder, disorder with anxiety, personal history of transcription of the April Physician's 4/25/12. The POS indedications: Paxil 20 anti-depressant, Hale anti-psychotic, Seroquanti-psychotic, Lorazorand Hydroxyzine 25 medications: Paxil 20 anti-psychotic, anti-anti-psychotic, anti-anti-psychotic, anti-anti-psychotic.	nt Guideline revised January to the initiation of tion a physician order is the diagnosis and targeted that the medication use."  Identify and monitor for cts of the psychotropic  Identify and monitor Identify and monitor Identify and monitor Ide	F	329			
		ressant, and anti-psychotic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  A. BUILDII			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G_		05/0	2/2012
	ROVIDER OR SUPPLIER  LIVINGCENTER - ESKRII	OGE		5	REET ADDRESS, CITY, STATE, ZIP CODE 605 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	listed the following be compulsive, false beli intrusive, inappropriat and trespassing. This medications: Paxil 20 Haloperidol 5 mg., Se 2 mg., and Hydroxyzi specify which medicate behaviors.  An observation on 4/3 seated in wheelchair slunch.  An interview on 5/1/12 nursing staff F indicate listed beside the prestargeted behaviors coappropriate diagnose:  An interview on 5/1/12 administrative nursing provide information of behaviors related to define the facility Behavior Managemer 2011, recorded "prior antipsychotic medicate obtained to include the behaviors that warrant.	Flow Sheet for April 2012, haviors: agitated, efs, striking out/hitting, e physical/sexual behavior, sheet listed the following milligrams (mg.), roquel 300 mg., Lorazepam ne 25 mg. This sheet did not tions were related to which 30/12 at 12:10 P.M. resident at dining room table eating 2 at 11:45 A.M. licensed ed that the diagnoses were cribed medications and the rresponded to the 3.  2 at 1:15 P.M. with a staff C was unable to a residents' targeted iagnosis and medications.  2 oolicy/procedure for the Guideline revised January to the initiation of ion a physician order is e diagnosis and targeted the medication use."	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		175455	B. WIN	G_		05/02	2/2012
	OVIDER OR SUPPLIER	DGE			REET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		.D BE	(X5) COMPLETION DATE
F 329	Continued From page	20	F	329			
	Order Sheet dated 4/3 had diagnoses that in extrapyramidal abnorn hypothyroidism, rash, anxiety, lipoid metabo disorder, peripheral v reflux disease, obesit osteoarthrosis involvi hypertension, and cor The resident's annual an assessment refere identified the resident	Minimum Data Set 3.0 with ence date of 12/29/11 had short and long term allucinations, delusions, and ychotics, antianxiety					
	the resident received Zyprexa (an antipsychatics), Atival Klonpin (an anti-anxiethe facility monitored related to his/her medithe resident's behavior.  The resident's March monthly flow sheet identified the resident for the focontinuous pacing, hallucinations/paranotea, refusing medicati	n (an anti-anxiety), and ety). The care plan included the resident for side effects lications and also monitored					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER:  A. BUIL			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175455	B. WIN	G		05/0	2/2012	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKR	RIDGE	•	505	T ADDRESS, CITY, STATE, ZIP CODE N. MAIN ST. KRIDGE, KS 66423			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
The resident's beha April and March 201 medications: Halope An interview on 5/0 licensed nurse F ab indicated that the fa beside the prescribe could not correlate the behaviors to the medications to the medications of the tall appropriate medication of the tall appropriate medication. An interview on 5/0 administrative nurse monitoring, and medications and information behaviors related to failed to provide more related to the medication aphysic include the diagnost warrant the medication. The clinical record lamonitored the effect	elationship of drug It specific targeted behaviors.  Vior monthly flow sheets for I2 listed the following eridol, Ativan, and Klonopin.  I/12 at 11:45 A.M. with out behavior sheets, the staff cility listed the diagnoses ed medications. The staff the resident's targeted dications.  I/12 at 4:00 P.M., with the arding targeted behaviors, e nurse could not relate the regeted behaviors to the tions.  I/12 at 1:15 P.M. e C about targeted behaviors, dications, the staff failed to on resident targeted the medications. This staff nitoring of targeted behaviors actions.  ated January 2011 indicated, on of an antipsychotics cian 's order is obtained to es and targeted behavior that	F	329				

Facility ID: N099002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0:	2/2012
	ROVIDER OR SUPPLIER	OGE	·	50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	edema, anxiety, iron of constipation, nutrition 1, allergic rhinitis, astipodies, neurogenic bleembolism and thrombe hypothyroidism, and it is set 7/11/11 identified (moderately cognitive Interview for Mental States delusions, and receivantidepressant medical The resident received Klonopin (an anti-anxing antipsychotic), Geodo (an antipsychotic), Geodo (an antipsychotic). The committened the resident received the medications and a behavior.  The resident's March monthly flow sheet identified the resident for the focrying, yelling, halluciand intrusiveness. The sheets failed to show class/names against the March and April 2 sheet listed the resident for the resident for the focrying, yelling, halluciand intrusiveness. The March and April 2 sheet listed the resident for the resident for the focrying, yelling, halluciand intrusiveness. The March and April 2 sheet listed the resident for the resident for the focrying in the March and April 2 sheet listed the resident for the resident for the focrying in the March and April 2 sheet listed the resident for the focrying in the formal and April 2 sheet listed the resident for the focrying in the formal and April 2 sheet listed the resident for the focrying in the formal and a fo	ed the resident had ed: paranoid schizophrenia, deficiency, anemia, al deficiency, diabetes type nma, dementia with lewy adder, depressive disorder, rosis of artery, nyperlipidemia.  Cant Change Minimum Data the resident scored 10 ly impaired) on the Brief status, had hallucinations, ed antipsychotics and ations.  an dated 3/22/12 included Celexa (an antidepressant), fiety), Clozaril (an on (an antipsychotic), Abilify ald Seroquel (an are plan included the facility after for side effects related to also monitored the resident's  and April 2012 behavior centified the facility monitored allowing behaviors: Agitation, mations/paranoia/delusion ne behavior monthly flow the relationship of drug specific targeted behaviors.  2012 behavior monthly flow ent received the following Geodon, Celexa, Seroquel,	F	329			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL B. WIN		<u></u> ,		
		175455	D. WIIN			05/0	2/2012
	OVIDER OR SUPPLIER  LIVINGCENTER - ESKRI	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page	23	F	329			
	indicated that the faci	ut behavior sheets, the staff lity listed the diagnoses I medications. The staff e resident's targeted					
	staff H regarding targ medications revealed	the nurse could not relate targeted behaviors to the					
	administrative nurse monitoring, and medi provide information o behaviors related to t	he medications. The staff toring of targeted behaviors					
	" Prior to the initiation medication a physicia	n's order is obtained to sand targeted behavior that					
		cked evidence the facility reness of the medications.					
	onychia and paronycl conditions classified	oses included: der chronic, hypertension, nia of toe, anxiety disorder elsewhere, generalized pain, tal disorder, unspecified,					

Facility ID: N099002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G	<del></del>	05/02	2/2012
	ROVIDER OR SUPPLIER	OGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 5 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	unspecified hypothyrous unspecified hypothyrous The annual MDS date resident had a brief in score of 15 (cognitive disorder with delusion anxiety with insomnia had setup assistance supervision at meals, activities was very impantipsychotic, antianximedication.  The care area assess for psychotropic medication.  The care area assess for psychotropic medication Lorazepan hypnotic medication A CAA showed the resident paranoia of other belongings were concentral illness with the medications.  The care plan dated a potential for drug rela associated with the unmedications and for the effects and report to the antidepressant sedative esteem. Interventions assess for pain, monital interventions and for the part of the part of the properties	poses and abnormal inspecified constipation, and oidism.  and 04/11/12 recorded the terview for mental status by intact), schizoaffective is and hallucinations, had a mood score of 0, with bathing and preferences for routine and portant, and received an iety, and hypnotic  ament (CAA) dated 4/11/12 cations recorded the oquel and Invega for er, the antianxiety in when necessary, and the ambien for insomnia. The dent had delusional thinking is, especially where his/her terned and became anxious her property. The resident in due to long term history of e use of high risk  and 11/12 reported the ted complications is e of psychotropic in e staff to monitor for side	F	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER:  A. BU			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G	<del> </del>	05/02	2/2012
	OVIDER OR SUPPLIER	OGE		50	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ON SHOULD BE CO IE APPROPRIATE	
F 329	constipation, blurred of syndrome (EPS), weight a care plan dated 4 related complications psychotropic medication and antipsychotic medication and antipsychotic medication, and for the tresident had a bowel days, and to be free complications.  Review of February 2 2012 behavior sheets 2012 the resident had pacing/restless behavior sheets 2012 the resident had 11 of 30 continuous behaviors had 18 of 30 days of plate the sheet shifts. The blisted behavior codes restlessness and elopshow the relationship against specific target sheets listed Seroque Invega 3mg, and Invented 156 mg for schizoaffe 2mg for anxiety, and an observation on 5/0 nursing staff F identifications.	ion, drowsiness, dry mouth, vision, extra pyramidal ght gain, and edema,  1/26/12 for potential for drug associated with use of ions related to: antianxiety dications (Ativan, Invega). The resident had ind was at risk for the staff to monitor if the movement at least every 3 of psychotropic related  1012, March 2012, and April reflected that in February 16 of 28 days of viors, in March 2012 the days of pacing/restless, in April 2012 the resident pacing, restless behaviors ehavior monitoring forms for "continuous pacing, rement risk," and failed to of drug class/names ted behaviors. The behavior of drug class/names ted behaviors. The behavior of the disorder, Lorazepam Ambien 15 mg for insomnia.	F	329			
	An observation 5/01/1	2 at 4:45 P.M., licensed					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		175455	B. WIN	IG_		05/0	2/2012	
	OVIDER OR SUPPLIER	DGE	<b>.</b>	,	REET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIOI TAG CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
F 412 SS=D	nurse G gave the resimedications which co Propranolol.  An interview on 5/01/licensed nurse F about indicated that the facibeside the prescribed could not correlate the behaviors to the medications to the medications reverselate the correlation of the appropriate medications reverselate the correlation of the appropriate medications related to the monitoring, and medications related to provide information of behaviors related to the failed to provide moniteriated to the medication. The facility policy date "Prior to the initiation medication a physicial include the diagnoses warrant the medication. The facility failed to identify	dent his/her 5:00 P.M. nsisted of Seroquel and  12 at 11:45 A.M. with ut behavior sheets, the staff lity listed the diagnoses medications. The staff e resident 's targeted cations.  12 at 4:00 P.M., with the ding targeted behaviors, aled the nurse could not of the targeted behaviors to cations.  12 at 1:15 P.M. with the C about targeted behaviors, cations, the staff failed to n resident targeted he medications. The staff toring of targeted behaviors tions.  ed January 2011 indicated, of an antipsychotic n 's order is obtained to s and targeted behavior that		329				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		ONSTRUCTION	(X3) DATE SUI	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	DGE	•	505 N.	ADDRESS, CITY, STATE, ZIP CODE MAIN ST. RIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 412	The nursing facility man outside resource, §483.75(h) of this par covered under the St dental services to me resident; must, if necessident; must, if necessident; must, if necessident appointments transportation to and must promptly refer redamaged dentures to the sample included 15 record review and intimely provide dental residents sampled for Findings included:  Review of resident Order Sheet (POS) is diagnoses that included disorder, hypothyroid depressive disorder, rhinitis, and esophage. The resident's annual 3.0 with an assessment identified the resident cognition) on the Bries Status, independent will living, and without swe MDS included the resident cognition and without swe MDS included the resident contents.	ust provide or obtain from in accordance with t, routine (to the extent ate plan); and emergency set the needs of each essary, assist the resident in s; and by arranging for from the dentist's office; and esidents with lost or a dentist.  The is not met as evidenced esidents. Based upon erviews the facility failed to services to 1 (#18) of 4 redental concerns.  #18's 4/2012 Physician dentified the resident had ed: Schizoaffective ism, essential tremors, constipation, insomnia, eal reflux disease.  I Minimum Data Set (MDS) ent reference date of 4/6/12 to scored a 15 (intact of Interview for Mental will all activities of daily rallowing difficulties. The sident had obvious or likely ral teeth, had mouth or facial	F	412			

Facility ID: N099002

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER	DGE	<b>.</b>	50	EET ADDRESS, CITY, STATE, ZIP CODE D5 N. MAIN ST. SKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY		LD BE	(X5) COMPLETION DATE
F 412	chewing.  The resident's dental dated 4/20/12 docum voiced complaints of was seen by the dent recommendations for have all of his/her upp CAA included the residentures following the The resident's care plincluded the resident problems related to his staff encouraged the oral care, staff perform assessments on their facility referred their eservice in an emerger services. The care plincluded that included the complaints of oral disidentist today, needed extraction, and the facts are gone that would act insurance. An entry of facility found an oral shis/her insurance, pathe resident's guardiat for services.  A nurse's note dated documented the resident pain, stated he/she have requested staff to not physician. The note in the complaints of the pain of the problems in the problems in the pain of the problems in the proble	care area assessment ented the resident recently oral pain and discomfort, ist on 4/3/12 with the resident to be referred per teeth extracted. The ident stated he/she wanted extractions.  an last reviewed on 4/11/12 had potential for oral aving his/her own teeth, resident to practice daily med regular oral esident's mouth, and the sident to an onsite dental ncy or for necessary an included an entry dated one resident voiced comfort, was seen by the la referral for tooth cility would find an oral	F	412			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER  LIVINGCENTER - ESKRI	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE D5 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 412	A nurse's note dated documented the faciliphysician, informed the not relieve the tooth pan order for 50 milligr medication) as needed.  A nurse's note dated documented the reside nothing was done exchis/her teeth, the reside nothing was done exchis/her teeth, the reside documented a recom an oral surgeon was facility would initiate a that is a medicaid process.  A dental progress not the resident presente poor oral hygiene, the his/her teeth 1 time p to brush his/her teeth resident needed refer upper teeth extracted resident's upper teeth and the resident would the upper denture and needed extracted by A psychosocial progress.	3/15/12 timed 10:15 P.M. ty contacted the resident's ne physician the Tylenol did pain, and the physician gave ams (mg) of Tramadol (pain ed.)  4/3/12 timed 9:56 P.M. dent saw the dentist today at nt was concerned that cept the dentist cleaned dent continued to complain urting and the facility would  4/4/12 timed 2:52 P.M. mendation for a referral to made for extractions, the a search for an oral surgeon wider in Kansas.  The dated 4/3/12 documented do for prophylaxis, had very the resident reported brushing the red out to have all of his/her. The note included the newer decayed and infected, and like an upper denture. Pressions were started for dother resident's teeth an oral surgeon.  The sees note dated 4/12/12 (time)		412	DEFICIENCY)		
	•	ed the resident had his/her endent in his/her oral care					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER:  A. BUIL			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG		05/0:	2/2012
	ROVIDER OR SUPPLIER	DGE	<u> </u>	5	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. ESKRIDGE, KS 66423	1 00/0/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF COMPRETIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 412	with some cueing from A mental health dental 8:01 A.M. documented tooth pull, was treated dental pain per nursing have it pulled and saithe director of nursing resident and explained gum pain and illustrated positioned in the gum stated it was okay to oral surgeon. The normental health service up today as the oral since the middle of late and the clinical record did spoken to the resident prior to 4/24/12. The evidence the facility he evaluation with the oral received 650 milligrame/she saw the dentist and also received 220 at 8:00 A.M. for tooth During interview with 8:15 A.M. the resident the dentist for tooth pand needed his/her uresident stated he/she teeth and gum discont the pain and the Tyle	al note dated 4/24/12 timed and the resident was to have a d for a couple of weeks for any, refused yesterday to dit is his/her gum that hurts, a services met with the ad how a tooth could cause ated how the tooth was any, and the resident then aset up an evaluation with the ate included the directory of as would set the evaluation surgeon had not been in st week.  If not support the facility had at regarding the extractions clinical record also lacked and attempted to set up the all surgeon prior to 4/24/12.  Int's April 2012 Medication of revealed the resident had ans of Tylenol 9 times since at on 4/3/12 for tooth pain 0 milligrams Aleve on 4/6/12	F	412			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER	DGE	<b>.</b>	5	REET ADDRESS, CITY, STATE, ZIP CODE 105 N. MAIN ST. ESKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THIS DEFICIENCY		LD BE	(X5) COMPLETION DATE
F 412	him/her as to when he surgeon.  During interview with 4/30/12 at 4:40 P.M. had complained of to ago, the resident was he/she did not know i complain of tooth pair.  During interview with 5/1/12 at approximate reported the resident after the dentist recor an oral surgeon, and Rehabilitation Service oral surgeon paymen dentist visit. Social Scontacted the oral sur ago tomorrow (on/or oral surgeon's office of Friday of the same we the paperwork to the Social Service staff D was completed, and the paperwork to the resisional service staff D paperwork back from facility would schedul resident's guardian.  During interview with C on 5/1/12 at 11:40 nursing department he paperwork from the of Administrative nursing departments.	direct care staff J on the staff stated the resident of pain a couple of weeks seen by the dentist and f the resident continued to the resident continued to the resident continued to the resident continued to the resident seen the dentist on 4/3/12, and the resident seen the she contacted Social and the resident seen the she contacted Social and the resident seen the shortly after the 4/3/12 the revice staff D stated he/she regeon office around 2 weeks the round 4/18/12), and the resident seek (4/20/12), he/she gave the shortly will forward the dent's guardian for consent. Stated once the paperwork the facility will forward the dent's guardian for consent. Stated after receiving the the resident's guardian the the resident's guardian the the administrative nursing staff P.M. the staff stated the administrative nursing staff P.M. the staff stated the ad not completed the	F	412			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	DGE	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428 SS=E	demographic and a beauty the pharmacist must the date of the attending physicial and a beauty and the pharmacist must the attending physicial and provided the pharmacist must the attending physicial and pharmacist and p	ealed the forms contained rief health history review. aled a facsimile date of .M.  administrative nursing staff kimately 1:15 P.M. the staff not completed the ot know when the paperwork et up an evaluation with an ely manner for this resident oth and/or gum discomfort. GIMEN REVIEW, REPORT		412			
	by: The facility identified The sample included observation, record refacility failed to identified to identified the ten residents reference in the ten reference in the	a census of 59 residents. 15 residents. Based on eview and staff interview, the fy and monitor targeted ropic medications for seven eviewed for unnecessary 6, #43, #25, #20, #27, #19).					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WING	3		05/0	2/2012	
	NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE			STREET ADDRESS, CITY, S 505 N. MAIN ST. ESKRIDGE, KS 664	·	,		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECT RRECTIVE ACTION SHOUI ERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 428	paranoid schizophre and recurrent seizure tremor, anxiety disord bodies, nutritional de disturbance, depress disturbance of skin separkinson's, bipolar behavioral disturbance sophagus, peripher anemia, obsessive of mellitus type I, and of Physician's Order State POS also include Lunesta 1 milligram Cymbalta 60 mg., ard 0.25 mg., an anti-psyanti-psychotic, and realitional sessent Referecorded a Brief Inter (BIMS) of 9 indicated impairment and receivant in the sessent receivant in the sessent receivant in the sessent receivant receivant in the sessent receivant	diagnoses that included nia, plantar wart, epilepsy es, constipation, essential der, dementia with Lewy eficiency, insomnia, sleep sive disorder, hypothyroidism, ensation, secondary disorder, dementia with ce, gastroparesis, Barrett's al angiopathy, cardiomegaly, ompulsive disorder, diabetis ataract as listed on the April neet (POS) dated 4/11/12. ed the following medications: (mg.), a sedative/hypnotic, anti-depressant, Risperdal ychotic, Geodon 60 mg., an Clonopin 0.5 mg., an	F4	228	DEFICIENCY)			
	12/14/11 for psychot documented he/she mental illness with the medications. The phemedication regimen with no new recommendation recommendation recommendation recommendation.	ropic medication usage had a long term history of the use of psychotropic armacist completed a review on a monthly basis thendations noted. The Nurse Practitioner (ARNP)						

Facility ID: N099002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A.			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG_	<del> </del>	05/0	2/2012
	OVIDER OR SUPPLIER	DGE	<b>.</b>	5	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. ESKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF OUT OF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO TOTAL DEFICIENCE PROVIDER'S PLAN OF OUT OF PROVIDER'S PLAN OUT OF PROVIDER'S PLAN OUT OF PROVIDER'S PLAN OUT OF PROVIDER'S PLAN OUT		LD BE	(X5) COMPLETION DATE
F 428	noted he/she was not dose reduction.  The care plan dated 3/20/12 recorded a prognitive or behavioral psychotropic medicat listed nursing staff monoted any decreased nursing staff reported changes in sleeping pursing staff reported changes in sleeping pursing staff reported Daily Living (ADL) fur the pharmacist review a monthly basis, and sugar candy for dry monoted the following beanxiety, continuous you hallucinations/paranous and refusing care. The medications: Lunesta sedative/hypnotic, Cyanti-depressant, Rispanti-psychotic, Geodo and Klonopin 0.5 mg. did not specify which which behaviors.  An observation on 5/2 resident consumed betable, stood up from the floor, then ambulators.	a current candidate for  12/29/11 and last reviewed of tential for drug related al impairment due to ion usage. The interventions onitored fluid intake and intake to the charge nurse, behavioral changes or bettern to the charge nurse, changes in Activities of action to the charge nurse, wed medication regimen on staff offered him/her hard mouth.  7 Flow Sheet for April 2012 chaviors: agitated, angry, celling, ia/delusion, skipping meals, is sheet listed the following 1 milligram (mg.), a mbalta 60 mg., an erdal 0.25 mg., an on 60 mg., an anti-anxiety. This sheet medications were related to 1/12 at 8:00 A.M. revealed reakfast at dining room the table, picked napkin off atted towards his/her room.	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G	<del> </del>	05/0	2/2012	
	ROVIDER OR SUPPLIER	DGE	<b>.</b>	5	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE		LD BE	(X5) COMPLETION DATE	
F 428	An interview on 5/1/1 nursing staff F indicat listed beside the prestargeted behaviors of appropriate diagnose.  An interview on 5/1/1 administrative nursing provide information of behaviors related to consultant completed medication basis. He/she monito recent lab work, and He/she stated specific specific targeted behaves.	2 at 11:45 A.M. with licensed ted that the diagnoses were scribed medications and the brresponded to the s.  2 at 1:15 P.M. with g staff C was unable to n residents' targeted diagnosis and medications.  2 at 12:50 P.M. with t N, stated he/she n monitoring on a monthly red medication orders, physician progress note. c medications did not have aviors as all the medication of the behaviors. He/she with the facility for targeted	F	428				
	medications.  An interview on 5/2/1 administrative staff A contacted consulting reported he/she did n recommendations on Review of the facility Behavior Managemet 2011, recorded "prior antipsychotic medica" obtained to include the behaviors that warrareserved.	2 at 3:30 P.M. with reported the facility pharmacist N on 5/2/12, and ot make any behavior monitoring forms.  policy/procedure for nt Guideline revised January						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SUF	
		175455	B. WIN	IG	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	irregularities and faile and the facility.  Resident #31 had oparanoid schizophrer due to mental disorded depressive disorder, amputation of arm an elbow, anxiety, consteyes, and agorapholisted on the April 201 (POS). The POS inclimedications: Trazodo anti-depressant, Clozanti-psychotic, Celexanti-depressant, and anti-anxiety.  The quarterly Minimu an Assessment Referecorded a Brief Inter (BIMS) of 15 which in cognitively intact and anti-anxiety, and anti-The Care Area Assestriggered for psychotromic side effects and tatarazadone, Clozaril, of the Behavior Monthly listed the following beyelling, and hyperventing the string and the process of the serior	liagnoses that included lia, hyperlipidemia, insomnia liagnoses that includes liagnoses that included liagnoses that inc	F	428			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175455	B. WIN	IG		05/0	2/2012	
	ROVIDER OR SUPPLIER	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		2/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	anti-psychotic, Celexamg. This sheet did nowere related to which An observation on 4/3 observed near the enthe smoking area, resequested staff to assescorted resident to huse walking cane dur. The drug regimen rev. 2/2/12, 1/4/12, and 12 medication irregularit. An interview on 5/1/1 nursing staff F indical listed beside the prestargeted behaviors coappropriate diagnose. An interview on 5/1/1 administrative nursing provide information obehaviors related to completed medication basis. He/she monito recent lab work, and He/she stated specific specific targeted behaviorelication was controlled.	a 20 mg., and Klonopin 1 bit specify which medications is behaviors.  30/12 at 10:20 A.M. resident strance door entering from sident held a cane and sist him/her to room, staff nis/her room, resident did not ing ambulation.  All the diagnoses these sies.  2 at 11:45 A.M. with licensed ted that the diagnoses were scribed medications and the corresponded to the s.  2 at 1:15 P.M. with g staff C was unable to n residents' targeted diagnosis and medications.  2 at 12:50 P.M. with	F	428				

Facility ID: N099002

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		175455	B. WIN	G	<del></del>	05/02	2/2012
	ROVIDER OR SUPPLIER  LIVINGCENTER - ESKRII	OGE		5	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	contacted consulting reported he/she did not recommendations on Review of the facility Behavior Managemer 2011, recorded "prior antipsychotic medicat obtained to include the behaviors that warrant. The Consultant N faile irregularities and faile and the facility.  Resident # 43 had dischizoaffective disord tissue infections, aller post-traumatic stress personality disorder, emellitus type II, urinar varicose veins of lower ovaries, obesity, Hirst atheroslerosis, tobacomyalgia and myositis, fibroadenosis of breast loss, lumbago, extern symptomatic menopa states, psychosis, real joints of pelvic region osteoporosis, constipmigraine, extrapyrami hypertension, and ins Physician's Order She	at 3:30 P.M. with reported the facility had charmacist N on 5/2/12, and of make any behavior monitoring forms.  colicy/procedure for at Guideline revised January to the initiation of ion a physician order is e diagnosis and targeted at the medication use."  ed to identify medication do to report to the physician order is ed to identify medication do to report to the physician do to report to the physician disorder, borderline esophageal reflux, diabetes y incontinence, rosacea, er extremities, polycystic atism, coronary to use, hyperlipididemia, osteoartherosis, anemia, et, sensoneural hearing all thrombosed hemorrhoids, usal/female climacteric ctive confusion, pain in	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/02/2012	
	ROVIDER OR SUPPLIER  LIVINGCENTER - ESKRII	OGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 95 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Zyprexa 10 milligrams Ativan 1 mg., an anti- an anti-depressant.  The quarterly Minimus 3.0 with an Assessme 2/17/12 recorded a Br Status (BIMS) of 15 w was cognitively intact and anti-depressant r  The Care Area Asses triggered for psychotr  The care plan dated 9 2/16/12 listed psychotr for side effects and ta Ativan, Paxil and Zyp  The Behavior Monthly listed the following be screaming/yelling, hallucinations/parano hoarding, damaging p items and then accus sheet listed the follow mg., an anti-psychotic anti-anxiety, and Paxi anti-depressant.  An observation on 4/3 the resident sat at the straight back chair	m Data Assessment (MDS) ent Reference Date (ARD) of rief Interview of Mental which indicated the resident and received anti-psychotic medications.  sment (CAA) dated 12/6/11 opic medication usage.  2/30/11 and last reviewed tropic medication monitoring rgeted behaviors included: rexa.  2/ Flow Sheet for April 2012 haviors: anxiety, continuous ia/delusions, isolation, property, and giving away ing others of stealing. This ing medications: Zyprexa 10 c, Ativan 1 mg., an 1 10 mg., an 1 10 mg., an 1 deining room table in a 1 diew dated 4/4/12, 3/2/12, 2/2/11 did not address these	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		175455	B. WIN	IG	<del></del>	05/0	2/2012
	OVIDER OR SUPPLIER	DGE	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	An interview on 5/1/1 nursing staff F indicated listed beside the prestargeted behaviors of appropriate diagnose. An interview on 5/1/1 administrative nursing provide information of behaviors related to consultant medication monitoring monthly basis. He/shorders, recent lab wo progress note. He/shorders, recent lab wo prog	2 at 11:45 A.M. with licensed ted that the diagnoses were cribed medications and the orresponded to the s.  2 at 1:15 P.M. with g staff C was unable to n residents' targeted diagnosis and medications.  2 at 12:50 P.M. with the total the	F	428			
		ort to the physician and the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Continued From page facility.	÷ 41	F	428			
	disorder with anxiety, personal history of tra mellitus type II, and a the April Physician's (4/25/12. The POS incomedications: Paxil 20 anti-depressant, Halo anti-psychotic, Seroquanti-psychotic, Loraze and Hydroxyzine 25 r. The significant chang 3.0 with an Assessme 2/7/12 recorded a Bric Status (BIMS) of 6 who was severely impaired anti-psychotic, anti-armedications.  The Care Area Assestriggered for psychotromic manti-anxiety, anti-depresentations.  The Behavior Monthly listed the following be compulsive, false beli	a, hypothyroidism, hyperlipidemia, adjustment psychosis, mood disorder, humatic brain injury, diabetes topic dermatitis as listed on Order Sheet (POS) dated cluded the following milligrams (mg.), an peridol 5 mg., an usel 300 mg., an anti-anxiety, ng., an anti-anxiety.  The Minimum Data Set (MDS) ent Reference Date (ARD) of the Interview for Mental hich indicated the resident dicognitively and received existery, and anti-depressant and anti-depressant sessent (CAA) dated 2/7/12 opic drug usage.  The Interview of the Interview of the Interview for Mental hich indicated the resident dicognitively and received existery, and anti-depressant sessent (CAA) dated 2/7/12 opic drug usage.  The Interview of the Interview					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	DGE		50	EET ADDRESS, CITY, STATE, ZIP CODE 95 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	and trespassing. This medications: Paxil 20 anti-depressant, Halo anti-psychotic, Seroquanti-psychotic, Loraze and Hydroxyzine 25 r sheet did not specify related to which behad An observation on 4/3 sat in a wheelchair at eating lunch.  The drug regimen reve 2/2/12, 1/4/12, and 12 medication irregulariti. An interview on 5/1/11 nursing staff F indicat diagnoses beside the the targeted behavior appropriate diagnose. An interview on 5/1/11 administrative nursing provide information of behaviors related to continuous. He/she monitor recent lab work, and in note. He/she stated shave specific targeted medication regime con He/she addressed the	sheet listed the following milligrams (mg.), an peridol 5 mg., an uel 300 mg., an epam 2 mg., an anti-anxiety, ng., an anti-anxiety. This which medications were viors.  30/12 at 12:10 P.M. resident the dining room table  siew dated 4/4/12, 3/2/12, 2/2/11 did not address these es.  2 at 11:45 A.M. with licensed ed that the facility listed the prescribed medications and s corresponded to the s.  2 at 1:15 P.M. with g staff C was unable to n residents' targeted liagnosis and medications.  2 at 12:50 P.M. with the N he/she stated he/she n monitoring on a monthly red medication orders, recent physician progress pecific medications did not	F	428			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		175455	B. WIN	IG		05/0	2/2012
	ROVIDER OR SUPPLIER	DGE		50	REET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		2/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY		JLD BE	(X5) COMPLETION DATE
F 428	medications.  An interview on 5/2/1 administrative staff A contacted the consult and reported he/she recommendations on Review of the facility Behavior Managemer 2011, recorded "prior antipsychotic medica" obtained to include the behaviors that warrar The Consultant N fail	2 at 3:30 P.M. with reported the facility ring pharmacist N on 5/2/12, had not made any behavior monitoring forms.  policy/procedure for the Guideline revised January	F	428			
	Order Sheet dated 4/had diagnoses that in extrapyramidal abnor hypothyroidism, rash, anxiety, lipoid metabor disorder, peripheral vereflux disease, obesit osteoarthrosis involvithypertension, and control of the resident's annual an assessment reference identified the resident	ng multiple sites, nvulsions.  I Minimum Data Set 3.0 with ence date of 12/29/11 t had short and long term allucinations, delusions, and sychotics, antianxiety					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		175455	B. WIN	G		05/0	2/2012
	OVIDER OR SUPPLIER	DGE	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 428	Continued From page	÷ 44	F	428			
	the resident received Zyprexa (an antipsychatics), Atival Klonpin (an anti-anxiethe facility monitored related to his/her medithe resident's behavior.  The resident's March monthly flow sheet identife the resident for the focontinuous pacing, hallucinations/paranotea, refusing medications showers, and continufailed to show the relactlass/names against of the resident's behavior. The resident's behavior April and March 2012 medications: Haloper Ativan (an anti-anxiety anti-anxiety).  The drug regimen revolucked evidence the pand communicated to regarding targaret belianticated that the facilitations in the facilitation of the facilitation	in (an anti-anxiety), and ety). The care plan included the resident for side effects dications and also monitored for.  and April 2012 behavior entified the facility monitored ellowing behaviors: Agitation, ia/delusions, demanding ons, refusing hygiene and ous physical aggression and elionship of drug specific targeted behaviors. For monthly flow sheets for elisted the following idol (an antipsychotics), y), and Klonopin (an eliew for 6/01/11-4/06/12 elharmacist had identified elie the facility staff the issue thaviors.  12 at 11:45 A.M. with the tat behavior sheets, the staff elity listed the diagnoses medications. The staff eresident's targeted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175455	B. WIN	IG		05/0	)2/2012
	ROVIDER OR SUPPLIER	DGE	<b>'</b>	505	T ADDRESS, CITY, STATE, ZIP CODE  N. MAIN ST.  KRIDGE, KS 66423	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	An interview on 5/01/licensed staff H regar and medications. The the correlation of the appropriate medication of the appropriate medication. An interview on 5/01/ladministrative nurse monitoring, and mediprovide information of behaviors related to the failed to provide mon related to the medication. An interview on 5/2/1 consulting pharmacis monitored on a month new orders, the meditor work. The consulting he/she reviewed new progress notes, report resident observation had decompensated. N reported that he/sh behavior issue to the had a discussion with consulting pharmacis health facility he/she to be controlling all of and that the physicial issue.  During an interview of administrative staff A contacted the consulting pharmacity and the consulting pharmacity and the consulting pharmacity issue.	12 at 4:00 P.M., with the ding targeted behaviors, a nurse was unable to relate targeted behaviors to the ons.  12 at 1:15 P.M. with the C about targeted behaviors, cations, the staff failed to n resident targeted he medications. The staff itoring of targeted behaviors tions.  2 at 12:50 P.M. with the N indicated that he/she haly basis the medications, cation rooms, and laboratory pharmacist N stated that psychotropic orders, new ted side effects, and made to determine if residents'  The consulting pharmacist e brought the targareted attention of the facility and the staff about it. The t N stated that in the mental considered all medications the resident's behaviors, in would have to address the modern of the facility ing pharmacist N on 5/2/12, iarmacist reported that any recommendations on	F	428			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET	
		175455	B. WIN	G		05/0	2/2012
	ROVIDER OR SUPPLIER	DGE		505 N	ADDRESS, CITY, STATE, ZIP CODE  I. MAIN ST.  RIDGE, KS 66423		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	Continued From page	e 46	F.	428			
	"Prior to the initiation medication a physicial include the diagnoses warrant the medication. The facility failed to it related to which psychehavior monitoring sefficacy.  Review of resident dated 4/11/12 identification diagnoses that included edema, anxiety, iron constipation, nutrition 1, allergic rhinitis, ast bodies, neurogenic be embolism and thrombe hypothyroidism, and I The resident's Signification of the resident cognitively impaired Mental Status, had have received antipsychotimedications.  The resident's care perior the resident received Klonpin (an anti-anxietantipsychotics), Geoca Abilify (an antipsychotics). The facility monitored the	an 's order is obtained to an use."  Identify which behaviors hotropic medications on the sheet for the monitoring of  #27's Physician Order Sheet ed the resident had ed: Paranoid schizophrenia, deficiency, anemia, al deficiency, diabetes Type hma, dementia with lewy ladder, depressive disorder, posis of artery, hyperlipidemia.  Cant change Minimum Data and treference date of 7/11/11 ascored 10 (moderately on the Brief Interview for allucinations, delusions, and ces and antidepressant).					

Facility ID: N099002

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	(X3) DATE SUF COMPLET	
		175455	B. WIN	IG	<del> </del>	05/0	2/2012
	ROVIDER OR SUPPLIER	DGE	·	5	REET ADDRESS, CITY, STATE, ZIP CODE 605 N. MAIN ST. ESKRIDGE, KS 66423	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	resident's behavior.  The resident's March monthly flow sheet id the resident for the fo Agitation, crying, yellin usion and intrusivene relationship of drug clargeted behaviors. behavior monthly flow received the following Geodon, Celexa, Sent The drug regimen revelacked evidence the pand communicated to regarding targaret be An interview on 5/01/licensed nurse F aboundicated that the faci beside the prescribed could not correlate the behaviors to the med An interview on 5/01/licensed staff H regar and medications. The the correlation of the appropriate medication of the appropriate medication on behaviors related to the staff of the staff of the provide information on behaviors related to the staff of the sta	and April 2012 behavior entified the facility monitored llowing behaviors: g,hallucinations/paranoia/del ss and failed to show the ass/names against specific. The March and April 2012 y sheet listed the resident medications: Ability, oquel, Clozaril and Klonopin.  The work of 6/01/11-4/06/12 oharmacist had identified the facility staff the issue haviors.  12 at 11:45 A.M. with the diagnoses medications. The staff e resident 's targeted cations.  12 at 4:00 P.M., with the ding targeted behaviors, a nurse was unable to relate targeted behaviors to the ons.  12 at 1:15 P.M. with the C about targeted behaviors, cations, the staff failed to a resident targeted behaviors he staff failed to a resident targeted behaviors.	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175455	B. WING			05/02/2012	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE				50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE	
F 428	An interview on 5/2/12 consulting pharmacis monitored on a month new orders, the media work. The consulting he/she reviewed new progress notes, repor resident observation thad decompensated. N reported that he/she behavior issue to the had a discussion with consulting pharmacis health facility he/she to be controlling all of and that the physician issue.  During an interview of administrative staff A contacted the consulting phe/she had not made the behavior monitorion. The facility policy date "Prior to the initiation medication a physicial include the diagnoses warrant the medication. The facility failed to id related to which psychological monitorion.	2 at 12:50 P.M. with t N indicated that he/she ally basis the medications, cation rooms, and laboratory pharmacist N stated that psychotropic orders, new ted side effects, and made to determine if residents' The consulting pharmacist the brought the targareted attention of the facility and the staff about it. The t N stated that in the mental considered all medications the resident's behaviors, the would have to address the  15/2/12 at 3:30 P.M. with the staff stated thefacility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility ing pharmacist N on 5/2/12, armacist reported that any recommendations on the facility and the staff about it. The the	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG	<del></del>	05/02	2/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE				5	REET ADDRESS, CITY, STATE, ZIP CODE 105 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF COMPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY		LD BE	(X5) COMPLETION DATE
F 428	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE			•	5	REET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 428	effects and report to the antidepressant sedation self-esteem. Intervention assess for pain, monifered to doctor any a effects such as sedat constipation, blurred to syndrome (EPS), weight and antipsychotic medicate a	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175455	B. WIN	IG		05/0	2/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE				5	REET ADDRESS, CITY, STATE, ZIP CODE 505 N. MAIN ST. ESKRIDGE, KS 66423	1 00/0	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY		LD BE	(X5) COMPLETION DATE
F 428	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	428			

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ESKRIDGE				50	EET ADDRESS, CITY, STATE, ZIP CODE 05 N. MAIN ST. SKRIDGE, KS 66423	1 00/0	
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F 428	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	428			